Alternative Meal: A vegetarian alternative to the standard facility master menu meal that is completely free of meat, poultry, fish, and their by-products; e.g., meat-based soups, gravies, and gelatin, or grilling using animal fats. This will be prepared as directed by the designated person in charge of food services at the local site.

Food Allergies: Adverse reactions to foods that are fought by the immune system and can be verified.

Food Preference: Foods that one personally prefers to consume.

Food Services Officer: A Department Correctional Officer (including CO I, CO II and Cook C) also serving in the role as food services staff, who plans menus, and orders and prepares food served to inmates in a correctional facility.

Medical Diet: Specific foods and/or food preparation techniques that satisfy medical diet therapy (including dental) requirements as prescribed by a qualified health care professional.

Qualified Health Care Professional (QHCP): Any person who by virtue of their education, credentials, and experience is permitted by law to evaluate and care for patients. This includes, but is not necessarily limited to, physicians, physician assistants, nurses, nurse practitioners, dentists, and mental health professionals.

Religious Diet: Specific foods and/or food preparation techniques that satisfy religious dietary requirements.

Restrictive Housing Status: A designation which provides for closely regulated management of inmates through placement on Administration Segregation status or by placement on Disciplinary Segregation.

Supplemental Snack: Foods that are prescribed by a qualified health care professional as medical therapy for a diagnosed medical or nutritional health problem.

PROCEDURAL GUIDELINES

1. Medical Diets

a. Authorization and Ordering Procedures

i. A qualified health care professional (QHCP) under contract to the Department will review and approve all medical diet requests prior to any authorization. The review includes any medical diet information provided by an inmate at their initial intake.

ii. Only a qualified health care professional may approve a medical diet for an inmate. If an inmate wants a medically-related diet, they must obtain approval from a qualified health care professional.

iii. A qualified health care professional will order a medical diet only when a medical or dental condition prevents the inmate from eating any of the particular food items prepared for the general population.

iv. Medical diets will not be ordered to accommodate an inmate's food preference, special request, or religious preference.

b. When a medical diet order is required, a qualified health care professional will initiate a *Medical Diet Form (Attachment 1).*

i. All required information on the *Medical Diet Form* will be provided.
ii. The duration of the diet must be indicated with a *start* and *stop date* shown. However, all initial diet orders may not exceed ninety (90) days prior to a medical review by a qualified health care professional.
iii. The medical diet will continue until ended by the review process.
iv. Medically-ordered supplemental snacks will be handled in the same manner as a medical diet and indicated on the *Medical Diet Form*.
v. The completed and signed *Medical Diet Form* will be kept in the inmate's medical file and copied to the Food Services Supervisor, Assistant Superintendent, and inmate.

c. A qualified health care professional will review the *Service Agreement for Medical/Nutritional Therapy (Attachment 2*) with the inmate and ask them to sign and accept or refuse the medical diet. The qualified health care professional will also sign the Agreement.

d. A medical diet will conform as closely as possible to the food served to other inmates for meals.

e. Any medical diet will be served in the dining area where meals are normally served unless an inmate resides in special (restrictive) housing.

f. The Department of Corrections' contracted registered dietitian will develop all prescribed medical menus.

g. A designated qualified health care professional at each facility will attempt to minimize unnecessary medical diet orders by educating inmates in proper self-care and nutrition.

h. In all cases, the qualified health care professional will document the condition requiring a medical diet in the inmate's medical records.

i. The Food Services Officer or Correctional Officer who supervises the tray delivery service on any unit with satellite feeding is responsible for documenting medical diet service.

j. Refusal of Medical Diet

i. An inmate may refuse a medical diet order by signing the *Service Agreement for Medical/Nutritional Therapy, Attachment 2* and checking the "I refuse" statement.
ii. When an inmate refuses a specific medical diet meal, the food services staff or correctional staff will notify a qualified health care professional. In every case, a qualified health care professional will counsel the inmate regarding the importance and medical necessity of compliance with the diet.
iii. The Food Services Officer or Correctional Officer who supervises the tray delivery service on any unit with satellite feeding will document any refusal of the medical diet by the inmate.

k. Transfer to Another Facility

When an inmate on a medical diet is transferred to another facility, all pertinent information regarding the diet will be entered in the medical record which accompanies

the inmate to ensure that the inmate receives their medical diet without delay. Staff will also forward a copy at the time of the transfer to the Food Services Supervisor at the receiving facility.

l. Food Allergy/Intolerance

i. If an inmate enters the DOC system with a confirmed, documented food allergy, a qualified health care professional will prescribe the appropriate diet based on the documented food allergy. (See *Medical Diet Form.*)

ii. A qualified health care professional will attempt to verify the allergy of any inmates claiming food allergies before the medical diet is ordered.

iii. A qualified health care professional will document the verification in the inmate's medical record and prescribe the appropriate medical diet.

iv. In the case of food allergies described by an inmate as life-threatening, any QHCP on duty will allow a food allergy medical diet for fourteen (14) days pending evaluation and verification by an MD, PA, APRN, NP, or WHNP.

v. Food services staff will prepare and serve a medically-appropriate diet modified for the diagnosed food allergies as written by the registered dietitian.

vi. A qualified health care professional and contracted dietary staff will:

a) Provide food substitution as recommended by the registered dietitian only if a food allergy renders the remaining diet inadequate, as in the case of:

- life-threatening allergies (e.g., severe reactions to tree nuts, peanuts, fish, shellfish, and in unusual circumstances, some beans);
- multiple food allergies (e.g., milk and citrus);
- an allergen that is a common ingredient in other foods (e.g., eggs);

b) Recommend replacement foods causing an allergic reaction(s) with similar foods of equal nutritional value when substitution is necessary;

c) Provide dietary education and recommend vitamin/mineral supplementation to the inmate per the dietitian's recommendation when appropriate;

d) Document all instructions regarding food allergies for an inmate in the medical file and forward a copy to Food Services staff.

vii. The inmate is responsible to:

- Provide needed information to help verify the stated food allergy;
- Employ self-selection to consistently avoid the allergen(s) for meals, snacks, and Commissary;
- Accept and adhere to appropriate dietary instruction;
- Notify a qualified health care professional and/or the Food Services Supervisor when legitimate allergy concerns arise.

2. Alternative (Vegetarian) Meal Diet Program

An inmate on an alternative meal diet program receives a vegetarian alternative to the standard menu for all meals provided by the facility. (See *Definitions.*) In most instances, the alternative meal diet as provided through the master facility menu will be sufficient to meet vegetarian and religious dietary requirements. However, this does not mean that if an inmate requests a pork-free diet for religious reasons that they should be treated as if they are a vegetarian. Alternative meals will be provided in accordance with the following program guidelines.

a. An inmate must complete the *Inmate Request for Religious Diet/Alternative (Vegetarian) Meal* form to request to be placed on an alternative meal diet, and give it to their Caseworker. (*See Attachment 3.*)

b. The Caseworker and the Food Services Supervisor will review the request and make a recommendation for approval or denial to the Assistant Superintendent.

c. The Caseworker will distribute copies of the approved or denied request to the inmate and the Food Services Supervisor and place the original in the inmate's file, and document in electronic case notes.

d. If the alternative meal program is approved by the Assistant Superintendent, participation by an inmate may be monitored in one of two ways:
   i. An inmate's ID card will indicate participation in the alternative meal program; or
   ii. A list of inmates authorized to participate in the alternative meal program wi be maintained in the food services area, as well as the inmate's housing unit.

e. Food services staff will strictly follow recipes; meat/poultry/fish and their by-products will be excluded (e.g., meat-based soups, gravies, and gelatin, or grilling using animal fats.)

f. Inmates on work camp status, who eat a meal away from the facility, will be provided with an alternative meal diet if they are approved for the alternative meal diet program.

g. An inmate who has been approved for the alternative meal diet and eats a non-vegetarian meal will be removed from the alternative meal diet program. The Food Services Officer will notify the approving authority of the removal.

h. An inmate who, for religious or other reasons, chooses not to eat pork or pork by-products may be served an alternative meal diet. An inmate who chooses not to eat pork will have their ID card marked as "No Pork", or have their name added to a list as referenced in d. ii. above.

i. Inmates on any Restrictive Housing status retain the right to participate in an alternative meal program.

3. Religious Diet

a. Religious Diet Request

Inmates for whom the alternative meal diet does not satisfy religious requirements may request a religious diet meal as prescribed by their religion. The process follows.

i. The inmate will complete and sign the *Inmate Request for Religious Diet/Alternative Meal* form, *Attachment 3.* The requesting inmate must also complete a *Religious Diet Participation Agreement, Attachment 4.*

ii. The inmate's assigned Caseworker and the Food Services Supervisor will review the request and make a recommendation to the Assistant Superintendent for final approval.

iii. If a determination is made that extraordinary accommodations may be necessary, the request will be forwarded for review to the Department Facilities Executive. The Executive will research the request and consult qualified faith group representatives in the community and the Department's legal division, as necessary, for assistance in designing an appropriate plan of action.

iv. The Caseworker will distribute copies of the approved or denied request and the *Religious Diet Participation Agreement*, if applicable, to the Food Services Supervisor and the inmate making the request, place the originals in the inmate file, and document in electronic case notes.

v. Upon an inmate's transfer to another facility, the religious diet will be continued. It is the inmate's responsibility to notify food services staff that they were receiving a religious diet at a previous facility.

vi. Inmates on any Restrictive Housing status retain the right to participate in a religious diet program.

vii. All religious diets must be handled through the process stated above. Religious diets may *not* be ordered by a qualified health care professional.

b. Religious Diet Preparation

Food services staff will prepare approved religious diets according to religious dietary requirements. The diet should be kept as simple as possible and should conform closely to the foods served to other inmates.

c. Holy Day Meals

i. The dietary requirements of religious holy days, including fasting periods, will be taken into consideration, as far as practical, through menu planning. Each facility will make a reasonable effort to accommodate recognized religious holy days requiring special foods or serving times.

ii. Some special food items may be available to inmates through the Commissary.

iii. With the approval of the Superintendent, volunteers may bring in special religious food items for holy days.

d. Diet Compliance and Removal from a Religious Diet

i. Inmates who have an approved religious diet have signed the *Religious Diet Participation Agreement*, agreeing to a number of conditions.

ii. Any staff member will bring incidents of non-compliance with these conditions to the attention of the inmate and record them on the *Religious/Alternative Diet Non-Compliance Report* (*Attachment 5*).

iii. A second offense within a one (1) year time period will result in cancellation of the diet for one (1) year from the date of the second offense.

iv. Staff will maintain written documentation regarding non-compliance, to support diet cancellations. (See *Attachment 5.*)

e. Voluntary Diet Cancellation

i. An inmate may request that their religious diet be cancelled. The request will be in writing, using the *Religious Diet Cancellation Request* form *(Attachment 6)*, and will be effective immediately.

ii. An inmate who voluntarily requests that their religious diet be cancelled must wait one (1) year before requesting the current diet be reinstated, unless a change of religious affiliation is approved, per administrative directive *#380.01 Religious Observance.* (See *Attachment 6.*)

4. Implementation Responsibility

a. The facility Superintendent is responsible to ensure that the procedures in this administrative directive are consistently and fairly applied and that records of inmate religious diet/alternative meal requests and compliance are maintained.

b. The facility Food Services Supervisor is responsible to ensure that approved alternative diet meals and religious diet meals are appropriately prepared.

TRAINING

a. The Director of Health Services must ensure that the Medical Contractor trains their respective staff on the requirements of this directive.

b. The Director of Security, Operations and Audits must ensure, through the appropriate Contractor, that food services staff receive appropriate training.

QUALITY ASSURANCE

a. The Superintendent, in conjunction with Facility Food Services staff, is responsible to ensure that the procedures in this Interim Procedure are consistently and fairly applied and that records of inmate religious diet requests and compliance are maintained.

b. The Medical Contractor is responsible for developing quality assurance procedures to ensure that medical diets are developed and followed according to this procedure, and that adequate documentation is maintained in medical records to support decisions to provide, reject, or discontinue medical diets.

c. The Hearings Administrator is responsible for providing quarterly reports on grievances regarding diet to the Executive Management Team.

d. The Director of Security, Operations, and Audits is responsible for developing quality assurance procedures to verify and validate local procedures and to gather information on trends and patterns into annual Facility reports to the Facilities Executive.

e. The Director of Security, Operations, and Audits, in conjunction with facility Superintendents, is responsible for using the information gathered through local and statewide quality assurance procedures to develop improvement or corrective plans.

ATTACHMENT 1 - SAMPLE

VT DOC CLINICAL SERVICES DEPARTMENT

MEDICAL DIET FORM

Attachment 1 - SAMPLE

Vermont Department of Corrections

Medical Diet Order Form

Inmate Name: _____ **Facility:** _____

PID #: _____ **Unit:** _____ **Date:** _____

DOB: _____ **Expiration Date:** _____

Start Date: _____ *(Only Verified Allergies can be written indefinitely)*

(Check one) { } NEW { } Renewal { } Cancel

Formulary Diets

{ } Clear Liquid *(Broths & Pulpless Juice, Jello)*

{ } Pureed *(for transition from liquid to soft)*

{ } Soft Diet *(for post surgery with low food tolerance)*

{ } Mechanical Soft *(Chopped by hand, Not blended)*

(No hard, crunchy or nuts/ground meats, canned or well cooked fruits & Veg.)

Diabetic & Weight Loss | { } AM

{ } 200 kcal Snack

{ } 1500 kcal ADA

{ } 1800 kcal ADA

{ } 2200 kcal ADA Heart Healthy

Also Used For:
Low Fat/Low Cholesterol, Low Satu
<10%, Balanced Sodium <3000mg,
>25g, Pregnancy & Lactation

{ } N.P.O. Nothing by Mouth

{ } Renal: *Consult Required*

{ } Allergies - Specific Food(s) _____

{ }Not Verified - *14 days to verify* Written by: _____

{ } Verified - *Indefinite* Verified by:

Non-Formulary Diets - RMD approval attachment required

Nutritional Objective: _____

_____

_____

Medications: _____

Height & Weight/BMI: Mental Health In

QUALIFIED HEALTH CARE INITIAL REVIEW: { } Approval Date: _____

Per Qualified Medical Provider *(Print)*: _____

(Sign): _____ APRN, NP, WHNP MD, PA,

90 Day Review Date: _____ Diet Continued: { } Y

(Date of review)

(Print Name and Sign) _____

Next Review Date: _____

CC: Food Service Supervisor, Inmate, Asst. Superintendent, Medical Department, Original to Medical File

Rev. June 2010

ATTACHMENT 2 - SAMPLE

VERMONT DEPARTMENT OF CORRECTIONS
SERVICE AGREEMENT FOR MEDICAL/NUTRITIONAL THERAPY

TO THE INMATE:

1. The Medical Diet:
- This is recommended as a part of your medical/nutritional treatment plan.
- At this time you have the right to refuse this treatment.
- In the future, through a written request to a qualified health care professional, you have the right to refuse your medical diet.

2. At Meal Service:
- You are required to follow the procedure as outlined by the Food Services Staff for receiving your medical diet during mealtimes.
- You are responsible for checking your tray for mistakes and reporting this to the Food Services Officer immediately.

3. Non-compliance of your Medical Diet is:
- Failure to pick up four (4) meals within a one (1) month period.
- Observations by the Food Services Staff that the diet is not being used properly; for example, selling food items from your medical tray.
- Observation that you were taking food from the regular line, or from other inmates in addition to, or in place of, your medical diet tray.
- Making Commissary purchases contrary to the foods included on your medical diet.

4. Discontinuance of the Medical Diet:
- Your medical record will contain at least one (1) note stating that you have been counseled regarding the need for the medical diet.
- Your failure to comply with the medical diet will result in diet discontinuance.
- You can notify the qualified health care professional in writing if you are requesting to cancel your medically-prescribed diet.
- If you take a regular diet tray instead of your medical diet tray, this may result in a cancellation of the medical diet.

5. Reinstatement of the Medical Diet:
- You must make an appointment to see the qualified health care professional to discuss reinstating your medical diet.
- The qualified health care professional will make the decision whether to reinstate the medical diet; this may include the decision to reinstate it for one (1) time only.

I understand the above information provided to me regarding my medical diet. (*Check one line below and sign this form.*)

_____ I *accept* the medical diet and will abide by the stated rules.

_____ I *refuse* the prescribed medical diet at this time. I reserve the right to reconsider at a later date and will make an appointment to see the qualified health care professional at that time.

Inmate Name: _____ *Inmate Signature*: _____
DOB: _____ Date: _____

Qualified Health Care Professional (*Name*):_____ *Signature:* _____
Date: _____

Cc: Food Services Supervisor, Assistant Superintendent, Medical Department, Inmate Medical File, Inmate

ATTACHMENT 3 - SAMPLE

VERMONT DEPARTMENT OF CORRECTIONS
INMATE REQUEST FOR RELIGIOUS DIET/ALTERNATIVE (VEGETARIAN) MEAL

The Vermont Department of Corrections offers an alternative meal program which has been designed to meet most religious diet requirements. Requests for dietary accommodations outside of the alternative meal program must be clearly stated with the corresponding religious dietary laws outlined in this request.

INMATE NAME: _____

DOB: _____

FACILITY: _____

HOUSING UNIT: _____

DATE OF REQUEST: _____

INMATE SIGNATURE: _____

☐ **ALTERNATIVE (VEGETARIAN) MEAL REQUEST ONLY** *(Check box.)*

☐ **RELIGIOUS DIET REQUEST** (*Check*)

FAITH GROUP AFFILIATION:

_____

MEMBER OF THIS GROUP SINCE:

_____

GROUP CONTACT PERSON:

_____

Name:

_____

Address:

_____

City, State, Zip:

_____

Phone Number:

_____

Foods Prohibited:	***Religious Dietary Laws Requiring the Prohibition:***	***Documentation of Dietary Laws: (Outline specific source or attach copies.)***

FOOD SERVICES SUPERVISOR /CASEWORKER or DESIGNEE RECOMMENDATIONS (*Check appropriate choice.*)

_____ **Religious Diet Recommended**
_____ **Religious Diet Not Recommended:** ***Request does not match faith group affiliation***
_____ **Religious Diet Not Recommended:** ***No religious basis for request***
_____ **Alternative Meal** ***(vegetarian)*** **Program Recommended**
☐☐☐☐_____ **Alternative Meal Program Not Recommended**
_____**Other diet recommended:** _____

SIGNATURE OF FOOD SERVICES REVIEWER: _____ **DATE:** _____

Caseworker Review Completed ☐ **Yes** **No** ☐

ASSISTANT SUPERINTENDENT ☐ **APPROVED:** _____**DATE:** _____

☐ **DENIED AND REASON(S) (Use back.)**

Cc: Food Services Supervisor, Assistant Superintendent, Inmate File, Inmate

ATTACHMENT 4 - SAMPLE

VERMONT DEPARTMENT OF CORRECTIONS
RELIGIOUS DIET PARTICIPATION AGREEMENT

I, _____, **at** _____
(Inmate - Print Name & DOB) *(Name of Facility)*

would like to participate in the **Religious Diet Program.** I understand that in order for me to be served a religious diet, special foods may have to be procured for me, and special preparation practices must be used. Therefore, I agree to abide by the following conditions:

1. I understand that I may change my religion and corresponding religious diet no more often than once (1x) each year.
2. I understand that if I voluntarily request that my religious diet be cancelled, I must do so in writing (*Religious Diet Cancellation Request form*), and I must wait for a period of one (1) year before requesting that my diet be reinstated or requesting a new religious diet.
3. During meals I will eat and possess on my food tray only those food items served as a part of the Religious Diet Program.
4. I will not purchase, possess, or consume any food items that are not permitted under my religious diet. I understand that my Commissary purchases will be routinely monitored.
5. I will not eat foods from the general facility diet that are in conflict with my religious diet.
6. I will follow all facility policies for dining in my facility.
7. I will not provide all or portions of my specially-prepared meal to other inmates.
8. I will not collect religious food items (or unauthorized amounts of Commissary items) in my cell/room.
9. I understand that should I violate one of the provisions in # 3, 4, or 5, I will receive one (1) written warning, but will be allowed to continue to participate in the Religious Diet Program.
10. I further understand that should I violate one of the provisions in # 3, 4, or 5 a second time within a one (1) year time period, I will be terminated from the Religious Diet Program for a period of one (1) year from the date of the second incident.

By my signature below, I acknowledge that I have read and/or discussed with a staff person the contents of this agreement. I further agree that if permitted to participate in the Religious Diet Program **I will abide by the conditions of participation set forth above in this agreement.**

Inmate Signature: _____ Date: _____

Caseworker Printed Name and Signature _____ Date: _____

Cc: *Food Services Supervisor*
Assistant Superintendent
Inmate File
Inmate

ATTACHMENT 5 - SAMPLE

VERMONT DEPARTMENT OF CORRECTIONS
RELIGIOUS/ALTERNATIVE DIET NON-COMPLIANCE REPORT

INMATE NAME:	**DOB:**	**DATE OF INCIDENT:**
FACILITY:	**UNIT:**	**TIME OF INCIDENT:**

I OBSERVED THE ABOVE-NAMED INMATE VIOLATING THEIR RELIGIOUS/ALTERNATIVE DIET PARTICIPATION AGREEMENT IN THE FOLLOWING MANNER: (Be specific: when, where, what food item(s), others involved, etc.)

FACILITY

Staff Reporter's Name: (*print*) _____

Date forwarded to Asst. Supt. & Food Services Supervisor: _____

Reporter's Signature: _____

Food Service Reviewer's Name (*print*)_____ **Date forwarded:**_____

Reviewer's signature: _____ **Date:**_____

Food Services Supervisor Signature: _____**Date:**_____

Assistant Superintendent's Signature: _____ **Action taken:**

Cc: *Food Services Supervisor*
Assistant Superintendent
Inmate File
Inmate

ATTACHMENT 6 - SAMPLE

VERMONT DEPARTMENT OF CORRECTIONS
RELIGIOUS DIET CANCELLATION REQUEST

I request that my religious diet be cancelled immediately. I understand that I must wait for a period of one (1) year before requesting that my diet be reinstated or before requesting a new religious diet.

INMATE NAME: _____ **DATE:** _____
(*print*)

INMATE SIGNATURE:

_____ **DOB:** _____

FACILITY: _____ **UNIT:** _____

Cc: Food Services Supervisor
Assistant Superintendent
Inmate File
Inmate

REQUEST FOR REASONABLE ACCOMMODATION/RESPONSE FORM

I. REQUEST	
Offender/Inmate Name: *(please print)*	
Date of Birth:	
Site (Facility or Field Office):	

Accommodation Requested/Needed: *(Answer the following questions if that is helpful to you.)*

1. What is the disability or impairment that requires an accommodation?

_____

2. What accommodation do you think you need? _____

_____

3. Why do you think that accommodation will help solve the problem?

_____

_____

(Continue on back if necessary.)

Offender/Inmate Signature		***Date***	
Staff or QHCP Who Received Request *(Print name & title))* **Request was verbal:** ☐ *(check)*		***Date Received***	

II. RESPONSE ***Staff return this form to Local ADA Site Coordinator.)***

The reasonable accommodation(s) requested above has (have) been:

☐ **Approved as Requested**

☐ **Modified (Approved)**
State reason why below.

☐ **Denied**
State reason why below.

Individualized Accommodation made, modified/denied:

_____

_____

_____

Other Comments: _____

Staff/QHCP: _____ _____ **Date:** _____
(Print Name) ***(Signature)***

(Continue on back if necessary.)

ADA Site Coordinator Review/Signature: _____ **Date:** _____
If approved, distribute copies. ***If modified or denied, send to ADA Director.***

ADA Central Director Review: _____ **Date:** _____
(Signature)

Agree with Denial or Modification: ☐ **Yes** ☐ **No**

cc: Medical File, Offender/Inmate File, Offender/Inmate, ADA Site Coordinator, Supt./District Manager, Caseworker/ PO, ADA Director
Rev. 10.09

INVESTIGACIÓN DEL PACIENTE
Receiving Screening
(Three page pathway)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

☐ Refusal of admission until medically cleared

CUESTIONARIO PARA EL PACIENTE (Explique todas las respuestas a las que responda con un "Sí")	Sí	No
1. ¿Alguna vez recibió o se encuentra recibiendo en la actualidad tratamiento para el asma, diabetes, convulsiones, tiroides, problemas cardíacos, presión sanguínea alta, problemas con hemorragias, enfermedades en los riñones u alguna clase de trastorno mental? En caso de que su respuesta sea afirmativa, explique: _____	S	N
2. ¿Alguna vez recibió o se encuentra recibiendo en la actualidad tratamiento para otro tipo de enfermedades o problemas de salud que no se mencionó anteriormente? En caso de que su respuesta sea afirmativa, enumere: _____	S	N
3. ¿Actualmente se encuentra tomando medicamentos que un médico o psiquiatra le haya recetado? En caso de que su respuesta sea afirmativa, enumere: _____ Fecha/Hora de su última dosis: _____	S	N
4. ¿Alguna vez contrajo Hepatitis, enfermedades venéreas o de transmisión sexual, VIH/ SIDA, TB, o cualquier otra enfermedad grave? En caso de que su respuesta sea afirmativa, enumere: _____ En caso de que su respuesta sea afirmativa, ¿recibió tratamiento? Indique cuándo/dónde: _____ Fecha de la última CD4/CD8 y Carga Viral: _____ Indicar el resultado si lo conoce: _____	S	N
5. ¿Alguna fue hospitalizado por indicaciones de un médico o psiquiatra? En caso de que su respuesta sea afirmativa, ¿dónde? _____ ¿Cuándo? _____ ¿Motivo? _____	S	N
6. ¿Sufre alguna molestia o malestar dental en al actualidad? En caso de que su respuesta sea afirmativa, describa: _____	S	N
7. ¿Se encuentra hacienda alguna clase de dieta específica recetada por un médico? En caso de que su respuesta sea afirmativa, explique: _____	S	N
8. ¿Consume medicamentos que no le fueron recetados por un médico? En caso de que su respuesta sea afirmativa, ¿de qué clase? _____ ¿Modalidad del consumo? _____ ¿Qué cantidad? _____ ¿Con qué frecuencia? _____ ¿Último consumo? _____	S	N
9. ¿Consume bebidas alcohólicas? En caso de que su respuesta sea afirmativa, ¿qué clase? _____ ¿Último consumo? ¿Qué cantidad? _____ ¿Con qué frecuencia? _____	S	N
10. ¿Alguna vez tuvo síndrome de abstinencia después de dejar de consumir alcohol o drogas? En caso de que su respuesta sea afirmativa, describa: _____	S	N
11. ¿Alguna vez recibió tratamiento por abuso de drogas o alcohol? En caso de que su respuesta sea afirmativa, indique dónde: _____ ¿Cuándo?_	S	N
12. Alergias: Enumere: _____	S	N
13. ¿Alguna vez resultó ser TB (tuberculosis) positivo en análisis hecho en la piel, estuvo expuesto a TB o le diagnosticaron TB? En caso de que su respuesta sea afirmativa, indique cuándo: _____ ¿Dónde?: _____	S	N
14. ¿Alguna vez recibió tratamiento por haber estado expuesto a TB (tuberculosis) o porque se lo diagnosticaron? En caso de que su respuesta sea afirmativa, indique dónde: _____ ¿Cuándo?: _____ ¿Tomó algún medicamento? _____ ¿Por cuánto tiempo? _____ ¿Cuál fue el nombre del medicamento? _____ ¿Dónde y cuándo se hizo la última radiografía de pecho? _____	S	N
15. En la actualidad, ¿tiene alguno de los siguientes síntomas: tos persistente, falta de aire, pérdida del apetito, fatiga, tos con sangre, sudor de noche o pérdida de peso sin motivo? En caso de que su respuesta sea afirmativa, explique: _____	S	N
16. Para mujeres: ¿está embarazada, acaba de dar a luz o abortar, está tomando pastillas anticonceptivas; tiene alguna molestia abdominal o pérdida de flujo? En caso de que su respuesta sea afirmativa, explique: _____ Fecha de la última menstruación: _____ En la actualidad, ¿ingiere metadona?_____	S	N
17. ¿Alguna vez se sintió o se siente ahora sin esperanzas? En caso de que su respuesta sea afirmativa, explique e incluya la historia clínica de su tratamiento: _____	S	N
18. ¿Alguna vez se consideró o trató de suicidarse? En caso de que su respuesta sea afirmativa, indique cuándo _____ ¿Por qué? _____ ¿Historia clínica del tratamiento del paciente externo? _____	S	N
19. En la actualidad, ¿siente que Ud. es se podría hacer daño a sí mismo? En caso de que su respuesta sea afirmativa, explique: _____	S	N
20. En la actualidad, ¿sufre alguna molestia mental? En caso de que su respuesta sea afirmativa, explique: _____	S	N
21. ¿Alguna vez fue víctima de un delito o maltratado mientras estuvo en prisión anteriormente? En caso de que su respuesta sea afirmativa, explique: _____	S	N

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INVESTIGACIÓN DEL PACIENTE
Receiving Screening
(Three page pathway)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

		S	N
22.	¿Alguna vez fue arrestado por algún delito que implique abuso sexual o estuvo sujeto a una medida disciplinaria durante prisión por agresión sexual? En caso de que su respuesta sea afirmativa, explique: _____		

VISUAL OBSERVATION (Explain all "Yes" answers) Circle Y or N

		Yes	No
23.	Is Inmate appearance abnormal in any way? (e.g., sweating, tremors, anxious, disheveled, evidence suggestive of trauma or abuse) If yes, describe: _____	Y	N
24.	Is Inmate behavior/conduct abnormal in any way? (e.g., disorderly, in-appropriate, insensible, psychotic, depressed, anxious, aggressive, grandiose ideations, delusions, hallucinations, etc.) If yes, explain: _____	Y	N
25.	Is Inmate state of consciousness abnormal in any way? (e.g., disoriented, delayed response, lethargic, etc.) If yes, _____	Y	N
26.	Is Inmate movement restricted or compromised in any way? (e.g., body deformities, physical abnormality, unsteady gait, cast or splint intake, etc.) If yes, _____	Y	N
27.	Is breathing abnormal? (e.g., persistent cough, hyperventilation, shortness of breath, dyspnea, etc.) If yes, explain: _____	Y	N
28.	Does inmate's skin or scalp have obvious lesions, lice or scabies, jaundice, rashes, bruises, edema, scars, tattoos, needle marks or other indications of drug abuse? If yes, explain: _____	Y	N
29.	Does Inmate exhibit characteristics of potentially being at risk for victimization (e.g., age, small build, femininity, 1st time offender, passive or timid appearance) If yes, explain: _____	Y	N

REMARKS: _____

_____ Education provided orally and in writing on Access to Healthcare

_____ Education provided orally and in writing on Sexual Assault Awareness

Blood Pressure	Pulse	Respirations	Temp	O_2 Sat

Do you currently have Health Insurance? Type: _____

☐ Yes ☐ No State: _____ Policy Number: _____

Respondí todas las preguntas de forma completa. Me informaron y recibí instrucciones sobre la forma de conseguir asistencia médica. Me informaron y recibí instrucciones sobre conocimiento de agresión sexual. Por medio del presente, expreso mi consentimiento para que Correct Care Solutions me proporcione asistencia médica.

Firma del paciente: _____ Fecha: __

Health Care Signature/Title: _____ Date: ____ Time: _____

INVESTIGACIÓN DEL PACIENTE
Receiving Screening
(Three page pathway)

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

PLACEMENT/HOUSING (please check)

- ☐ General Population (GP)
- ☐ Medical Housing in observation unit
- ☐ Isolation
- ☐ Emergency Room for evaluation/treatment
- ☐ Referral for emergency mental health intervention
- ☐ GP with Referral (check appropriate box)
  - ☐ Medical
  - ☐ Mental Health
  - ☐ Dental

Screening Exceptions

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Booking Date / Time: _____ Screening Date / Time: _____

Reason for Exception:

__ Inmate Combative

__ Inmate Physically Unavailable (state reason) _____

__ Extremely Intoxicated – being held by security

__ Inmate Refusing

__ Other (state reason) _____

Screening Nurse Signature: _____

Intake Sergeant Signature: _____

This form is to be completed by the assigned Screening Nurse at the end of the first 2 hours and signed by both the Nurse and Intake Sergeant.

If the screening is not completed by the end of the shift, the form is then to be passed on to the oncoming shift, who will attach it to a copy of the screening form once the screening is completed.

Both are to be turned in to the H.S.A. when completed.

D2502DP22074PNXN

Transportation Form

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Appt Date: _____ **Appt Time:** _____

Inmate Name: _____

Inmate #: _____

Housing (if applicable): _____

DOB: _____

Transport From: _____

Location: _____

Contact Name: _____

Phone: _____

Transport To: _____

Address: _____

Phone: _____

Contact Name: _____

Special Directions: _____

Special Instructions for Officers:

Additional Precautions suggested *(Medical suggests use of universal precautions with all offenders):*

☐ Mask ☐ Gown ☐ Goggles ☐ Gloves ☐ Other _____

Special Restrictions / Precautions *(i.e. patient has cane, non-ambulatory, blind, etc):*

THIS ENVELOPE CONTAINS CONFIDENTIAL MEDICAL INFORMATION AND SHOULD ONLY BE OPENED BY MEDICAL PERSONNEL.

INSTRUCTIONS FOR CLINIC OR ER STAFF:

Please complete the Consultation Form enclosed and make a copy for your files. Place the Consultation Form and any other papers in the envelope and give it to the transporting officer to bring back to the jail.

Thank you.

D2505DP24281PNXN

GreenMountainCare
A HEALTHIER STATE OF LIVING

Health Care Programs Application

Name _____ **Social Security No.** _____

Green Mountain Care is the name of our health care programs for Vermonters. We will screen you for the health care program for which you are eligible. In order to do so, we may ask you for more information. If you are eligible, you may have to pay a premium based on your income.

Applying for these programs is a multi-step process. Start by filling out this form.

Health Care programs include:

- **Dr. Dynasaur** - for children under 18 and pregnant women.
- **Vermont Health Access Plan (VHAP)** - for uninsured Vermonters 18 and older.
- **Premium Assistance** - for uninsured Vermonters age 18 and older to help pay for health insurance at your job or Catamount Health premiums.
- **Pharmacy Programs** – for Vermonters age 65 and older or disabled. Coverage ranges from full pharmacy coverage to supplemental coverage for those on Medicare.
- **Medicare Savings Programs** – for individuals with Medicare to help pay for Medicare premiums, deductibles and co-pays.
- **Healthy Vermonter Program** – for all Vermonters without pharmacy coverage. This program provides a discount on some prescriptions.

We may ask you to provide proof of your citizenship and/or identity if we are not able to find you in the state's records, like Department of Motor Vehicles or birth records. ***Do not send anything at this time. We will tell you more about this after we get your application.***

The Americans with Disabilities Act gives people with disabilities certain rights. We will make reasonable changes and accommodations in our requirements to help you take part in our programs. If you think you might have a physical or mental condition that considerably limits a major life activity like moving, seeing, or thinking, contact us for help.

Children who are members of **federally designated American Indian or Alaska Native tribes** may not have to pay a premium.

If you have questions or need interpretation services, call the number below: (English)

- Si vous avez des questions ou avez besoin de services de traduction, appelez le: (French)
- Ukoliko imate dodatnih pitanja ili Vam je potreban prevodilac, javite se na: (SerboCroatian)
- Si tiene preguntas o necesita servicios de interpretación, por favor llame al teléfono a continuación: (Spanish)
- Haddii aad su'aalo qabto ama aad u baahan tahay adeeg tarjumaan, wac lambarka hoos ku qoran: (Somali)

1-800-250-8427 (TDD: 1-888-834-7898)
www.GreenMountainCare.org

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT FOR CHILDREN & FAMILIES

Applicant Information

Full Name	Social Security No.	Date of Birth

Mailing Address (Required)

_____

_____

City State Zip Code

Physical address (If different from above)

Phone No. ( ) Home ☐ Cell ☐ Work ☐

Phone No. ( ) Home ☐ Cell ☐ Work ☐

E-Mail Address

1. Are you applying for benefits for yourself? ☐ YES ☐ NO

GENDER
- ☐ Female
- ☐ Male

Birth Place _____

Citizenship Status:
- ☐ U.S. Citizen
- ☐ Legal Alien
- ☐ Refugee
- ☐ Asylee
- ☐ Other

Marital Status:
- ☐ Never Married / Single
- ☐ Married
- ☐ Separated
- ☐ Widowed
- ☐ Divorced / Dissolved
- ☐ Civil Union

2. Do you have an authorized representative or legal guardian? ☐ YES ☐ NO

If yes, check one
- ☐ Authorized representative
- ☐ Legal guardian - name of court _____ Date appointed_____

Full name	Phone no. ( ) Home ☐ Cell ☐ Work ☐
Address	Phone no. ( ) Home ☐ Cell ☐ Work ☐

Sending letters (notices) or premium bills to someone else:

- **Legal guardian:** If you have a legal guardian, your notices and premium bills will only be mailed to them.
- **In care of:** We can mail your notices and bills in care of someone else. This means you will not get notices or bills.
- **Alternate Reporter:** We can mail most notices to you and to someone else. We call this person an "alternate reporter." However, some notices will only go to one person or the other, so this may not be a good choice (i.e. premium bills will only go to you).

If you have questions or would like one of these options, please call 1-800-250-8427.

Household Information

If you live alone, skip to question 3. MEMB

We need information about the following people living in your household even if they are not asking for assistance. Please answer questions 3 to 21 for any people in the following groups:

- Your spouse or civil union partner.
- Your parents and siblings, if you are under age 21.
- Your children, under age 21 who are living with you.
- The parent of your child, (even if you are not married) if you are living in the same household.

Send proof of immigration status for anyone applying who is not a citizen.

People who are not applying do not have to give their social security number, citizenship, or immigration status information.

You do not have to provide information about other relatives or other people living in the same household who are not related to you.

Household Information (continued)

First Name	M.I.	Last Name

GENDER ☐ Female ☐ Male
Birth Date ____________
Birth Place ____________
Social Security No. ____________
Relationship to you ____________

Check here if this person is not applying ☐

Citizenship Status
☐ U.S. Citizen
☐ Legal Alien
☐ Refugee
☐ Asylee
☐ Other

Marital Status
☐ Never Married / Single
☐ Married
☐ Separated
☐ Widowed
☐ Divorced / Dissolved
☐ Civil Union

First Name	M.I.	Last Name

GENDER ☐ Female ☐ Male
Birth Date ____________
Birth Place ____________
Social Security No. ____________
Relationship to you ____________

Check here if this person is not applying ☐

Citizenship Status
☐ U.S. Citizen
☐ Legal Alien
☐ Refugee
☐ Asylee
☐ Other

Marital Status
☐ Never Married / Single
☐ Married
☐ Separated
☐ Widowed
☐ Divorced / Dissolved
☐ Civil Union

First Name	M.I.	Last Name

GENDER ☐ Female ☐ Male
Birth Date ____________
Birth Place ____________
Social Security No. ____________
Relationship to you ____________

Check here if this person is not applying ☐

Citizenship Status
☐ U.S. Citizen
☐ Legal Alien
☐ Refugee
☐ Asylee
☐ Other

Marital Status
☐ Never Married / Single
☐ Married
☐ Separated
☐ Widowed
☐ Divorced / Dissolved
☐ Civil Union

First Name	M.I.	Last Name

GENDER ☐ Female ☐ Male
Birth Date ____________
Birth Place ____________
Social Security No. ____________
Relationship to you ____________

Check here if this person is not applying ☐

Citizenship Status
☐ U.S. Citizen
☐ Legal Alien
☐ Refugee
☐ Asylee
☐ Other

Marital Status
☐ Never Married / Single
☐ Married
☐ Separated
☐ Widowed
☐ Divorced / Dissolved
☐ Civil Union

First Name	M.I.	Last Name

GENDER ☐ Female ☐ Male
Birth Date ____________
Birth Place ____________
Social Security No. ____________
Relationship to you ____________

Check here if this person is not applying ☐

Citizenship Status
☐ U.S. Citizen
☐ Legal Alien
☐ Refugee
☐ Asylee
☐ Other

Marital Status
☐ Never Married / Single
☐ Married
☐ Separated
☐ Widowed
☐ Divorced / Dissolved
☐ Civil Union

If you need to list more people, please use the blank page on the back of this application.

Household Information (continued)

ALIA

3. Has anyone been known by another name, such as a maiden name or alias? ☐ YES ☐ NO

Current Name First Name	M.I.	Last Name	Other Name First Name	M.I.	Last Name
Current Name First Name	M.I.	Last Name	Other Name First Name	M.I.	Last Name

SCHL

4. Is anyone in high school, college, vocational school, or a training program? ☐ YES ☐ NO

First Name	M.I.	Name of School:	Expected completion date	Is health insurance offered?	Attendance status
				☐ YES ☐ NO	☐ Full time ☐ Half-time ☐ Less than half-time
				☐ YES ☐ NO	☐ Full time ☐ Half-time ☐ Less than half-time

5. Does any child listed above have an Individualized Education Program (IEP) or a disability preventing graduation before age 19? ☐ YES ☐ NO

6. Is anyone in your household a parent to your minor child (under age 21)? Do not list your spouse or civil union partner. ☐ YES ☐ NO

PREG

7. Is anyone pregnant? ☐ YES ☐ NO

First Name	M.I.	Expected due date	How many babies?_____

ABSP

8. Are there children in your home who do not have both parents living with them? ☐ YES ☐ NO

a. Absent parent's full name and address	Social security #	Date of birth	Children of absent parent
			1.
Your relationship to absent parent ☐ Married ☐ Civil Union ☐ Divorced/dissolved ☐ Never Married ☐ Check if above parent is deceased	1) Has the absent parent been in jail? ☐ YES ☐ NO		2.
Absent parent's current marital status ☐ Married ☐ Civil Union ☐ Divorced/dissolved ☐ Never Married ☐ Check if above parent is deceased	2) Is the absent parent unemployed? ☐ YES ☐ NO		3.
	3) Is the absent parent unable to work due to physical or mental health issues? ☐ YES ☐ NO		4.

b. Absent parent's full name and address	Social security #	Date of birth	Children of absent parent
			1.
Your relationship to absent parent ☐ Married ☐ Civil Union ☐ Divorced/dissolved ☐ Never Married ☐ Check if above parent is deceased	1) Has the absent parent been in jail? ☐ YES ☐ NO		2.
Absent parent's current marital status ☐ Married ☐ Civil Union ☐ Divorced/dissolved ☐ Never Married ☐ Check if above parent is deceased	2) Is the absent parent unemployed? ☐ YES ☐ NO		3.
	3) Is the absent parent unable to work due to physical or mental health issues? ☐ YES ☐ NO		4.

If you need to list more people, please use the blank page on the back of this application.

Health Insurance Information

MEDI

9. Do you have Medicare? If no, skip to question 11.	Applicant	Spouse or Civil Partner
	☐ YES ☐ NO	☐ YES ☐ NO
a. Medicare claim number	Begin date_____	Begin date_____
b. Part A (hospital coverage)	Begin date_____	Begin date_____
c. Part B (medical coverage)	Begin date_____	Begin date_____
d. Part C (managed care)	Begin date_____	Begin date_____
e. Part D (drug coverage)	Begin date of current plan _____	Begin date of current plan_____
f. Part D Plan Name (if applicable)		
g. Part D Contract & Plan ID# Contract and Plan ID numbers are found in the bottom right-hand corner of your Medicare drug plan card.	CMS -_ _ _ _ _-_ _ _	CMS -_ _ _ _ _-_ _ _

10. Have you applied for Medicare "extra help" through Social Security?	Applicant	Spouse or Civil Partner
	☐ YES, granted ☐ YES, denied ☐ NO	☐ YES, granted ☐ YES, denied ☐ NO
a. If granted, begin date?		
b. If denied, what reason did Social Security give you?	☐ Over income ☐ Over resource ☐ Failed to cooperate ☐ Other; explain:	☐ Over income ☐ Over resource ☐ Failed to cooperate ☐ Other; explain:
c. If you did not apply, what was your reason?	☐ Over income ☐ Over resource ☐ Other; explain:	☐ Over income ☐ Over resource ☐ Other; explain:

INSU

11. Does anyone have health insurance, including veteran's, or military? If no, skip to question 13. ☐ YES ☐ NO

- Include insurance for any child in your home even if they are covered by a parent not in your home.
- Do not include Medicare or Green Mountain Care programs (Dr. Dynasaur, VHAP, Premium Assistance and Pharmacy Programs).
- **Please send copies of both sides of all insurance cards.**

Name of policy holder		Services covered (check all that apply)	Names of people covered	Name, address, phone # of insurance company
Policy Number	Group Number	☐ Doctors/Hospitals ☐ Outpatient ☐ Prescriptions ☐ Dental ☐ Vision		
Premium amount $ per	Date coverage began			

11. Continued Health Information (continued)

Name of policy holder		Services covered (check all that apply)	Names of people covered	Name, address, phone # of insurance company
Policy Number	Group Number	☐ Doctors/Hospitals ☐ Outpatient ☐ Prescriptions ☐ Dental ☐ Vision		
Premium amount $ per	Date coverage began			

12. Could anyone else in your family be covered under the above plan? ☐ YES ☐ NO

First name	M.I.	First name	M.I.

LOSS

13. Has health insurance ended for anyone in the past 12 months? Or will health insurance end in the next 60 days? Do not include Green Mountain Care Programs (Dr. Dynasaur, VHAP, Premium Assistance or Pharmacy Programs). ☐ YES ☐ NO

First name	M.I.	Date ended	Reason

If you need to list more people, please use the blank page on the back of this application.

If you lost your health insurance due to domestic violence, check here. ☐ YES

14. Does anyone have unpaid medical or dental bills? If you become enrolled in Medicaid, we may be able to help you pay them if the services were received in the past 3 months. ☐ YES ☐ NO

Who has the unpaid medical bills?	Provide an estimate of charges incurred within the last 3 months	Provide an estimate of charges incurred more than 3 months ago

Income Information

JINC

15. Does anyone have income from a job, internship or training program? ☐ YES ☐ NO

- List income from the past 30 days before any deductions such as taxes, insurance, child support, or union dues.
- Include income of children (under 21 and living with you) from a job or training program.
- If income has ended or you expect it to change in the next 30 days, attach a note explaining the change.

Full Name	Date paid	Hours worked	Income before deductions	Tips and commissions
Paychecks are issued ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Day of week_____			$	$
			$	$
			$	$
Employer's name and phone number			$	$

Full Name	Date paid	Hours worked	Income before deductions	Tips and commissions
Paychecks are issued ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Day of week_____			$	$
			$	$
			$	$
Employer's name and phone number			$	$

Income Information (continued)

If you claim income for providing daycare in your home on your taxes, answer question 18 instead of question 16.

DCIN

16. Does anyone get paid for taking care of children in your home? ☐ YES ☐ NO

List income from the past 30 days before deductions. List the number of meals you provide each month for which you are not paid/reimbursed.

First name	M.I.	Income before deductions	Breakfast	Lunch	Dinner	Snack
		$ per				

RBIN

17. Does anyone get paid for providing room or meals in your home? Include payments from children. ☐ YES ☐ NO

First name	M.I.	Payment	Name of people paying	Check all that apply
		$ per		☐ Room ☐ 1-2 meal/day ☐ 3 meals/day
		$ per		☐ Room ☐ 1-2 meal/day ☐ 3 meals/day

BUSI

18. Does anyone have income from self-employment, such as farming, home party sales, logging or property rental? ☐ YES ☐ NO

- Send copies of your most recent federal tax return, including all forms and schedules.
- If you have not filed taxes, and it is a new business, send income and expense records to date. If the business is ongoing, send income and expense records for the past year.
- If income has ended or you expect it to change in the next 30 days, attach a note explaining the change.

First name	M.I.	Type of business	Date business began

UNEA

19. Does anyone have unearned income? Some examples are: ☐ YES ☐ NO

Social Security	unemployment	veteran's compensation	Insurance settlement
Dividends or interest	SSI/AABD	worker's compensation	veteran's pension
Trusts or annuities	child support	pensions or retirement	money from others

List gross income (before any deductions such as Medicare premiums, taxes, insurance, child support, or union dues).

First name	M.I.	Income before deductions	Type of income	Due to disability?
		$ per		☐ YES ☐ NO
		$ per		☐ YES ☐ NO
		$ per		☐ YES ☐ NO

19a. If you have no income, please tell us how your daily living expenses are paid. _____

DCEX

20. Does anyone pay court ordered child support or alimony? ☐ YES ☐ NO

Name of Person Paying	Child support paid	Alimony paid	Names of children for whom support is paid
	$ per	$ per	
	$ per	$ per	

21. Does anyone pay for daycare? ☐ YES ☐ NO

Name of Person Paying	Amount paid	Name of child or adult in daycare	Reason
	$ per		☐ working ☐ looking for work ☐ going to school
	$ per		☐ working ☐ looking for work ☐ going to school

Signature Page

You must sign here

I give my word, under penalty of perjury, that the information I give in this application is true and complete to the best of my knowledge and belief. I have read and I understand the Rights and Responsibilities on the back of this application and I agree to them.

Signature of applicant _____ Date _____

Signature of person helping fill out this form _____ Date _____

Return this application to:

DCF, Economic Services Division
Application and Document Processing Center
Dale Building, Ground Floor
103 South Main Street
Waterbury, VT 05671-1500

We will let you know if we need more information. You will hear from us within 30 days. For questions call 1-800-250-8427 or TDD 1-888-834-7898.

The applicant is responsible for the accuracy of information given on this application including information about the applicant's husband, wife, or civil union partner.

Other Programs

Voter Registration: If you are not registered to vote where you live now, would you like a voter registration application? ☐ YES ☐ NO

If you do not check either box, you will be considered to have decided not to register at this time. Applying or declining to register will not affect your eligibility for benefits or the amount of benefits. If you believe that someone has interfered with your right to register or decline to register to vote, you may file a complaint with the Secretary of State's Office at Redstone Building, 26 Terrace Street, Drawer 09, Montpelier, VT 05609-1101 (telephone (802) 828-2363).

Lifeline may provide a discount on your phone bill. If you are not receiving a discount now, would you like to? **If yes, include a copy of your phone bill with this application.** ☐ YES ☐ NO
To learn more about this program call toll free at 1-800-479-6151

Link Up may pay for part of the installation cost of a new phone. You can get these benefits if you are 18 or older and on a Green Mountain Care program. The phone must be listed in your name or you must pay part of the bill. *Call your telephone company to learn more.*

Weatherization: This program helps with insulating, caulking, or weather-stripping your home or apartment to lower your heating costs. Would you like us to refer you to this program? ☐ YES ☐ NO
To learn more about this program call toll free 1-877-919-2299.

WIC: The Special Supplemental Nutrition Program for Women, Infants, and Children offers health screening, nutrition education, and food for pregnant women, nursing women, and children under five. Would you like someone from the WIC program to contact you? ☐ YES ☐ NO
If you checked yes, what is your phone number? Phone No: (___)_____
To learn more about this program call toll free 1-800-464-4343.

Fuel Assistance: This program helps to pay heating bills. Applications are accepted July 15 through the last day of February. Your local ESD office can give you an application during this time. You may also ask the Office of Home Heating Fuel Assistance to mail you an application in June. *To learn more about this program or to request an application call toll free 1-800-479-6151.*

3SquaresVT: Help to pay for food. If you have little or no money for food, you may be able to get emergency help. *For information or an application call 1-800-479-6151.*

Rights and Responsibilities

True and Complete Information.
I understand information I provide to the Department for Children and Families (DCF) will be subject to verification by federal and state officials to determine if it is correct. This means that sources other than members of my household may be contacted to verify my eligibility. I understand that if any information is not true I may be denied assistance.

Reporting Changes.
I understand that I must report changes in information reported in this application within 10 days from when they happen by calling Member Services at 1-800-250-8427.

Confidentiality.
Information in this application is confidential. DCF will not share any information from this application except when needed for program administration. For more information see release of medical records below.

Release of Medical Records.
I agree that my health care providers and the Office of Vermont Health Access and its contractors and grantees may access, use and disclose my medical records when necessary for the purpose of administering state health care programs or when a hospital, health care provider, mental health provider, or pharmacy needs my medical records, including provider and prescription medication information, for my treatment, for payment of my treatment, and for health care operations.

I agree that my consent includes the re-disclosure of prescription medication information received from a drug or alcohol treatment program when such information is needed for purposes of treatment. I understand that my consent to the use of my medical records remains in place until my eligibility is reviewed. I also understand that I can revoke my consent to the release of my medical records by putting my revocation in writing and mailing it to DCF, ESD Deputy Commissioner, 103 S. Main Street, Waterbury, VT 05671-1201.

Social Security Number.
I understand that I must give the social security number of everyone in my household who is applying for assistance. Federal law requires this as a condition of eligibility. If I am a member of a religious organization that objects to furnishing a social security number, AHS may disregard this requirement (42 U.S.C. §1320b-7).

DCF uses social security numbers for computer processing, child support enforcement, fraud investigation, audits, and Lifeline identification; to verify social security and supplemental security income; to prevent individuals from receiving duplicate benefits; to exchange information with agencies such as the Social Security Administration, Department of Labor, Internal Revenue Service, or private agencies to verify income, determine eligibility and benefit amounts, and collect claims; to determine the accuracy and reliability of information given to DCF; and to make medical assistance payments.

Rights and Responsibilities (continued)

Discrimination.
DCF does not discriminate based on race, color, national origin, sex, age, disability, marital status, sexual orientation or place of birth. To file a discrimination complaint, write Health and Human Services, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201; call (202) 619-0403 or (202) 619-3257 (TDD); or write to DCF, ESD Deputy Commissioner, 103 S. Main Street, Waterbury, VT 05671-1201.

Decision on Application.
DCF must make a decision on my application no later than 30 days after my application date (or 90 days if my Medicaid application is based on disability) unless delay is caused by physicians, an unexpected emergency or administrative problem beyond the Department's control, or me. If I do not get a decision within 30 days (or 90 days), I may call Member Services at 1-800-250-8427 for more information or to request a fair hearing.

Grievance Appeals & Complaints.
I may ask for a fair hearing if benefits or services are denied, or I am not responded to with reasonable promptness by calling the ESD Benefits Service Center at 1-800-479-6151, by calling Member Services at 1-800-250-8427 or by writing to the Human Services Board, 120 State Street, Montpelier, VT 05620-4301 (3 V.S.A. §3091).

For health care program actions that, for example, deny, limit, reduce, or end a service or deny a request to go outside the provider network, I may also request an appeal in addition to or in place of a fair hearing. If I have a complaint, for example, about the quality of the health care service or the behavior of staff for matters not related to health care program action, I may be able to file a grievance. For more information on any of these choices, call Member Services at 1-800-250-8427.

Quality Control Review.
DCF may select my application for a quality control review. I agree to cooperate and give proof of required information. If I am not able to give the proof needed, I authorize DCF to get it.

Assignment of Medical Support and Third Party Payments.
As a condition of eligibility for health care assistance, I agree to assign to DCF all rights to medical support and to third party payments (such as insurance) for medical care. I agree to enroll in a group health plan if the state requires me to, and I understand the state may pay all or part of the premiums.

I also agree to cooperate in pursuing any actual or potential source of support or payments, including establishing paternity for my dependent children, if necessary. I understand that if I do not cooperate, my health care benefits will end although my children's health care will continue.

Fleeing Prosecution.
I certify that neither I nor any member of my household is fleeing prosecution or confinement for a felony or an attempt to commit a felony, or is violating a condition of probation or parole under a federal or state law. I understand DCF must disclose information to law enforcement agencies to apprehend fleeing felons.

Rights and Responsibilities (continued)

Benefits from Another State.
If any member of my household gets heath care benefits from another state or has been convicted in the past ten years of fraudulently misrepresenting residence in order to get benefits from two or more states, I must notify DCF immediately by calling Member Services at 1-800-250-8427.

Fraud Penalties.
I or any member of my household will be subject to prosecution for fraud or some other criminal offense for knowingly giving false, incorrect, incomplete, or misleading information in order to get, try to get, or help someone else get health care benefits. If convicted, penalties may include up to three years of imprisonment and/or a fine of up to $1000, or another amount equal to the benefit wrongly received. Federal or state penalties may also apply.
(42 U.S.C. §1320a-7b; 33 V.S.A. §§141, 143).

Consent to bill Medicaid if Child Receives Special Education Services.
I give permission to my child's school district to bill Medicaid for the specified services listed in his/her Individual Education Plan (IEP). I understand that if I refuse consent, my refusal only affects Medicaid billing of IEP services; my refusal does not relieve the school district of its responsibility to provide IEP services at no cost to me. I understand that I may revoke this consent to bill Medicaid for IEP services at any time. If I revoke this consent it will apply to billing for services from that date forward. I can revoke my consent by writing to the address below.

Extra page for your use (If needed).

Weekender Receiving Screening

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Age	Height	Weight	B/P	Pulse	Resp	Temp

Visual Observation: *(explain all "Yes" answers)*	
1. Is inmate showing visible signs of illness, injury, bleeding, pain or other symptoms suggesting the need for immediate emergency medical referral? If yes:	☐ Yes ☐ No
2. Are there any visible signs of fever, persistent cough, lethargy, tremors, sweating, jaundice, skin lesions, rash or infection, cuts, bruises or minor injuries, needle marks, body vermin? If yes:	☐ Yes ☐ No
3. Does the inmate exhibit any signs that suggest the risk of suicide, assault or abnormal behavior? If yes:	☐ Yes ☐ No
4. Does the inmate appear to be under the influence of or withdrawing from drugs or alcohol? If yes:	☐ Yes ☐ No
5. Is the inmate's mobility restricted in any way due to deformity, cast, injury, disability, etc? If yes:	☐ Yes ☐ No
Inmate Questionnaire: (explain all "Yes" answers)	
6. Heave you had or been treated for any new conditions (circle as appropriate): asthma, diabetes, epilepsy, heart condition, high-blood pressure, mental health problems, seizures, ulcers or other conditions? If yes: Last time you drank?	☐ Yes ☐ No
7. Have you taken or are you taking any additional medication(s) prescribed for you by a physician or psychiatrist? If yes:	☐ Yes ☐ No
8. Are you allergic to any medications, food, plants, etc? If yes:	☐ Yes ☐ No
9. Have you fainted or had a head injury within the last 72 hours? If yes:	☐ Yes ☐ No
10. Do you have (circle as appropriate): a chronic cough, bloody sputum, extreme tiredness, weakness, recent weight loss, loss of appetite, fever or night sweats, or past positive PPD? If yes:	☐ Yes ☐ No
11. Are you considering harming yourself or others at this time? If yes:	☐ Yes ☐ No
12. Do you have a painful dental condition(s)? If yes:	☐ Yes ☐ No
13. Are you on a specific diet prescribed by a physician? If yes:	☐ Yes ☐ No
14. FEMALES: a. Are you or could you be pregnant? Are you currently on Methadone? b. Have you recently delivered a baby or had an abortion? c. Are you having abdominal pain or a discharge? d. When was your last menstrual period?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Placement Recommendation:

☐ Emergency Room ☐ General Population ☐ Infirmary ☐ Isolation
☐ Suicide Watch ☐ Next Sick Call ☐ *Release of Information Signed*

REMARKS:

I have answered all questions truthfully. I have been told and shown how to obtain medical services while here. I hereby give my consent for professional services to be provided to me by and through Correct Care Solutions.

Patient Signature _____ Date _____

Nurse Signature _____ Date _____

D2500DP30225P

Weekender Receiving Screening
INVESTIGACIÓN DEL PACIENTE

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Age	Height	Weight	B/P	Pulse	Resp	Temp

Visual Observation: *(explain all "Yes" answers)*

1.	Is inmate showing visible signs of illness, injury, bleeding, pain or other symptoms suggesting the need for immediate emergency medical referral? If yes:	☐ Yes ☐ No
2.	Are there any visible signs of fever, persistent cough, lethargy, tremors, sweating, jaundice, skin lesions, rash or infection, cuts, bruises or minor injuries, needle marks, body vermin? If yes:	☐ Yes ☐ No
3.	Does the inmate exhibit any signs that suggest the risk of suicide, assault or abnormal behavior? If yes:	☐ Yes ☐ No
4.	Does the inmate appear to be under the influence of or withdrawing from drugs or alcohol? If yes:	☐ Yes ☐ No
5.	Is the inmate's mobility restricted in any way due to deformity, cast, injury, disability, etc? If yes:	☐ Yes ☐ No

Inmate Questionnaire: (explain all "Yes" answers)

6.	¿Ha recibido tratamiento por alguno de estos problemas nuevos? (circule cuando sea apropiado): asma, diabetes, epilepsia, enfermedad cardíaca, presión sanguínea alta, problemas de salud mental, convulsiones, úlceras u otros problemas Si la respuesta es sí:	☐ Si ☐ No
7.	¿Ha tomado o está tomando alguna medicina adicional prescrita por su médico clínico o psiquiatra? Si la respuesta es sí:	☐ Si ☐ No
8.	¿Es alérgico a alguna medicina, alimento, planta, etc.? Si la respuesta es sí:	☐ Si ☐ No
9.	¿Se ha desmayado o ha sufrido una lesión en la cabezaen las últimas 72 horas? Si la respuesta es sí:	☐ Si ☐ No
10.	¿Sufre de (circule según sea apropiado): tos crónica, esputo ensangrentado, cansancio extremo, debilidad, pérdida reciente de peso, falta de apetito, fiebre o Si la respuesta es sí:	☐ Si ☐ No
11.	¿Está considerando lastimarse a usted mismo o lastimar a otros en este momento? Si la respuesta es sí:	☐ Si ☐ No
12.	¿Posee problemas dentales dolorosos? Si la respuesta es sí:	☐ Si ☐ No
13.	¿Se encuentra realizando una dieta específica prescrita por un médico? Si la respuesta es sí:	☐ Si ☐ No
14.	MUJERES: a. ¿Usted está o existe la posibilidad que usted esté embarazada? ¿Actualmente está tomando metadona? b. ¿Ha tenido recientemente un bebé o un aborto? c. ¿Está sufriendo de dolor abdominal o descarga de flujo? d. ¿Cuándo fue su último período de menstruación?	☐ Si ☐ No ☐ Si ☐ No ☐ Si ☐ No ☐ Si ☐ No

Placement Recommendation:

☐ Emergency Room ☐ General Population ☐ Infirmary ☐ Isolation
☐ Suicide Watch ☐ Next Sick Call ☐ *Release of Information Signed*

REMARKS:

He respondido a todas las preguntas con sinceridad. Me han explicado y mostrado cómo obtener servicios médicos mientras me encuentro aquí. Por la presente doy mi consentimiento para recibir servicios profesionales de Correct Care Solutions.

Patient Signature _____ Date _____

Nurse Signature _____ Date _____